transformation

of North Carolina's System of Services
for Mental Health, Developmental Disabilities
and Substance Abuse

the state strategic plan: 2007-2010

July 1, 2007

North Carolina
Department of Health and Human Services

Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

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Division of Mental Health, Developmental Disabilities and Substance Abuse Services

VISION

- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.
- Services for persons with mental illness, developmental disabilities and substance abuse problems will be cost effective, will optimize available resources – including natural and community supports – and will be adequately funded by private and public payers.
- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/ training, rehabilitation and recovery.
- All organizations and individuals that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

MISSION

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.

GUIDING PRINCIPLES

- Participant-driven
- Community based
- Prevention focused
- Recovery and/or self-determination outcome oriented
- Reflect best treatment/support practices
- Cost effective

CHAPTER 1 | *A Journey of Transformation*

Introduction

Six years ago North Carolina charted a course to reform the services it provides for people who experience mental illness, developmental disabilities and substance abuse. The journey began in 2001 when the General Assembly set initial expectations for reform of the publicly funded system.[1] The legislature mandated transformation of the way services were managed and delivered in the state. The required changes affect virtually every individual involved in the system – consumers and family members, management and staff of state-operated facilities and community service providers, and state and local government. As a result, there have been and continue to be many ideas about the new system of services, as well as the natural resistance to such a major change.

In response to the mandate, the North Carolina Department of Health and Human Services and its Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) embarked on the journey by publishing State Plan 2001: A Blueprint for Change. Since that time, the Division has published an annual plan on July 1 of each state fiscal year through 2005. In response to Session Law 2006-142, the Division reviewed all previous plans and produced a single document of the still applicable provisions. That analysis was published October 2006.

Progress of Reform: 2001 through 2006

Over the years, the Division and system stakeholders have been involved in numerous efforts to reach consensus to substantially transform the types of services offered, as well as the manner in which the system operates. Ongoing dialogue has produced areas of both agreement and disagreement on what the system could become and highlighted shortfalls in the present service delivery system. As on any journey, ongoing agreement about the destination is essential. Thus, it continues to be necessary for the Division, Local Management Entities (LMEs) and other state agencies to collaborate with consumers, their families, providers and other professional organizations.

A number of recommendations for next steps in the process are provided in the Long-Range Plan and a Funding Allocation Report produced for the Division through competitively bid contracts awarded to Heart of the Matter, Inc. and Pareto Solutions, LLC, and presented to the Legislative Oversight Committee in January of 2007.[2] The final reports suggest policy changes designed to address service

[1] See North Carolina Session Law 2001-437, House Bill 381, Section 1.5.

[2] See North Carolina Session Law 2006-276, Senate Bill 622, Section 10.24.

gaps. The Department of Health and Human Services is already moving forward on pursuing some of the suggestions that can be implemented within existing statutory authority. In addition, the Division has given thoughtful consideration to the recommendations in the process of developing this strategic plan. A matrix showing the recommendations and the current response is shown in Chapter 3.

North Carolina has made significant progress during the past six years in meeting the challenges of implementing the requirements of transformation. The 25 accomplishments shown in Table 1 were selected from many to demonstrate the enormity of this statewide undertaking. These and many other accomplishments provide the baseline and foundation for moving forward.[3]

1	Twenty-five accomplishments during 2001-2006 in community services, facilities and system organization and operation
1	Expanded access and provided services to more consumers.
2	Designed and implemented statewide a new array of best practices and evidence-based mental health and substance abuse services.
3	Implemented a redesigned Medicaid waiver for individuals with developmental disabilities (CAP-MR/DD) that provides more flexibility and lays the foundation to move to self-directed services. The CAP-MR/DD Waiver added over 3,050 Medicaid-eligible individuals in 2006.
4	Allocated more than $50 million in Mental Health Trust Funds to address system transformation and capacity building needs.
5	Implemented new rules for Child Residential Treatment providers designed to improve the health and safety of children served in those facilities through increased staffing and increased staff qualifications.
6	Allocated funding to support dedicated System of Care liaisons in each LME to better coordinate services for children following the System of Care best practice model.
7	Created the North Carolina Practice Improvement Collaborative (PIC), a group of clinical leaders, research leaders and consumers and advocates, to evaluate new and promising services to ensure that North Carolina offers the best possible array of services for individuals with mental illness, developmental disabilities and substance use disorders.
8	Funded six new Oxford Houses for adults recovering from substance use disorders, bringing the total number in North Carolina to 106, providing homes for nearly 800 people.

[3] Please see additional details regarding accomplishments that were drawn from two documents shown on the Division's web page: www.ncdhhs.gov/mhddsas/stateplanimplementation/index.htm. Click on documents named: (1) Milestones and Accomplishments and (2) Tasks and Outcomes.

1	Twenty-five accomplishments during 2001-2006 in community services, facilities and system organization and operation
9	Developed and implemented, in partnership with the North Carolina Housing Finance Agency, a program of rental subsidies to assist individuals with disabilities in obtaining safe, decent and affordable housing. Expanded the program with support from the General Assembly in 2006 to build and provide rental assistance for an additional 400 housing units.
10	Through a contract with consultants, the Division developed a long-range plan report and a cost model to determine the cost of providing needed services in the community. Concurrent with this long-range plan and cost model, developed the finance and allocation model to assist in determining how services might be funded and how to reduce funding variability among LMEs to ensure an equitable distribution of resources.
11	Permanently closed 539 state psychiatric hospital beds and transferred over $15.4 million in annual recurring savings from the hospitals' budgets to the community to pay for community services.
12	Permanently closed 82 beds in the state developmental centers and transferred $4.1 million in Medicaid from centers' budgets to the CAP-MR/developmental disabilities program to pay for community services.
13	Created a redesigned evidence-based treatment model for the alcohol and drug abuse treatment centers (ADATCs). Established 15 additional acute beds at the R. J. Blackley Alcohol and Drug Abuse Treatment Center and opened 10 new acute beds at Julian F. Keith Alcohol and Drug Abuse Treatment Center.
14	Assessed all consumers served in state psychiatric hospitals and state developmental centers to determine their interest in and need for community services.
15	Converted Black Mountain Center from an Intermediate Care Facilities for the Mentally Retarded to a Skilled Nursing Facility, providing a new model of care for people with developmental disabilities who are aging and have health care needs.
16	Began construction of a new state psychiatric hospital in Butner to replace aging facilities at Dorothea Dix and John Umstead Hospitals.
17	Established the Specialized Treatment for Adolescents in a Residential Setting Program (STARS) by realigning 18 Whitaker School beds to the Murdoch Center.
18	Created the State Consumer and Family Advisory Committee (SCFAC) for consumers and family members to provide advice and input to the Department of Health and Human Services and the Division. Required and facilitated the creation of local consumer and family advisory committees for each LME.

1	Twenty-five accomplishments during 2001-2006 in community services, facilities and system organization and operation
19	Facilitated transformation of area authorities and county programs from the role of service provision to LMEs. Mergers have reduced the number of LMEs from 40 to 30, more closely in alignment with the original mandate of the General Assembly. Most LMEs have successfully recruited providers and divested service provision in accordance with legislative requirements that they focus on management functions.
20	Reorganized the Division of Mental Health, Developmental Disabilities and Substance Abuse Services along functional lines to correspond to the requirement of reform including establishing an Advocacy and Customer Service Section within the Division.
21	Implemented a provider endorsement process to ensure that providers enrolling in the Medicaid program to serve individuals with mental health, developmental disabilities and substance abuse services needs meet minimum quality requirements.
22	Implemented new information technology systems to track system performance and guide policy decisions based upon quantifiable data through: a) the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS), an on-line system that tracks outcomes for all consumers with mental illness and substance use disorders and measures providers' performance in achieving positive outcomes, and b) the Integrated Payment and Reporting System (IPRS) for data on state-funded services and supports to consumers.
23	Created a Cultural and Linguistic Competency Advisory Committee to recommend strategies to ensure that services meet the needs of varied populations within North Carolina. Adopted and published a Cultural and Linguistic Competency Action Plan.
24	Created and implemented various committees, communications series, trainings and interactive events to improve communication with all participants and interested individuals: a) the External Advisory Team comprised of advocates, consumers, provider trade associations, the North Carolina Council of Community Programs, and other stakeholders to provide advice and guidance on policy decisions; b) the Provider Action Agenda Committee deals with the needs of providers in the new, privatized service delivery environment; c) hosted 16 Town Meetings across the state; d) created communication bulletins and implementation updates to inform the system; and e) created the Division's web site as a means to facilitate communication and reference for policy and events.
25	Jointly conducted with the Division of Facility Services licensure reviews in 1,054 child/adolescent residential facilities. These reviews found that 305 facilities were vacant and that 83 of the vacant facilities had never served any clients, 458 facilities had standard deficiencies, 71 had administrative sanctions and 105 surrendered their license to operate. As of December 2006, there were 635 qualified and licensed facilities.

Values and Principles

An essential part of clarifying the destination is coming to an agreement on the values and principles that guide decision-making. For system reform to be comprehensive and enduring, it must be based on values and principles that reflect the consensus of stakeholders in the system, as well as national perspectives and scientific findings.

Many federal reports have stated the need for transformation of the country's mental health system. In 1999, the U.S. Surgeon General released a report on mental health services that recognized the importance of recovery in adult mental health. The 2003 final report of the President's New Freedom Commission on Mental Health called for "recovery to be the common recognized outcome of mental health services." That report defines recovery as referring *"...to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms."* Recovery has also been adopted by SAMHSA as a significant outcome for substance abuse services. The report described the mental health system throughout the country as fragmented, complex and filled with gaps, unmet needs and barriers that mandated a complete system transformation and not just a reform of the existing system to fully reflect the implications for policy, funding and practice as well as attitude and belief shifts.

In a transformed mental health system, people understand that "mental health is essential to overall health; mental health care is consumer and family driven and recovery oriented; disparities in mental health services are eliminated; early mental health screening, assessment, and referral to services are common practice; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health care and information." (President's New Freedom Commission).

A transformed system of community-based substance abuse services incorporates proven psychosocial interventions such as cognitive behavioral therapy, contingency management and motivational enhancement therapy. Additional best practices include the use of medications for specific diagnoses; screening and brief intervention in primary care settings; expanded post treatment care; and provision of case management, wrap-around and supportive services. In North Carolina, as in most other states, there is also a need to extend substance abuse treatments to a larger proportion of the priority consumers that need such services. Nationally, only about 10 percent of people with substance abuse receive treatment, and of those that do receive treatment, less

than 50 percent receive evidence base care.[4]

In a transformed developmental disabilities system, people are supported to make choices about where they live, work and enjoy leisure activities; resources are allocated based on individual needs and preferences; people are supported to be members of their communities and to build lasting relationships; families receive the information, resources, and support that they need; direct support staff are trained and competent; and individual health and well being is assured.

The Guiding Principles

The Division adopted six "Guiding Principles" that encompass expectations, desired outcomes, and elimination of barriers. These principles drive the ongoing progress. They provide a solid basis for comprehensive reform of the current system and are consistent with areas of concern that have achieved consensus among stakeholders. The Division's guiding principles describe a system that is:

- Participant-driven.
- Community based.
- Prevention focused.
- Recovery and/or self-determination outcome oriented.
- Reflect best treatment/support practices.
- Cost effective.

Implementation of the guiding principles envisions a sustainable system in which consumers and family members are involved in the planning and management of system services. Additionally, adherence to the guiding principles create conditions under which all people experience a system that protects consumer's rights, provides detailed descriptions of core services and service standards, has a uniform portal of entry and exit, targets services to specific populations and promotes intersystem collaboration.

During the development of this strategic plan, the Division, with the assistance of consultants from Technical Assistance Collaborative, Inc. (TAC) and Human Services Research Institute, Inc. (HSRI), identified key concerns and issues that cut across all activities for the next three years. The table below provides more detailed aspects of the guiding principles that will assist the Division with assuring that current concerns and ongoing values reinforce reform of the mental health, developmental disabilities and substance abuse services system as envisioned by the North Carolina legislature. They include:

[4] This information is summarized from the Robert Wood Johnson Foundation "Advancing Recovery" program.

Consumer and Family Principles
Consumers and families involvement in planning and management of system services*
Protection of consumer rights*
Recovery or self-determination
Choice and self-direction of services

System Principles
Continuity of care
Description of core services* and service standards for the mental health/developmental disabilities/substance abuse system*
Implementation of uniform portal*
Targeted populations and criteria for identifying them*
Integration and best use of state facilities with community systems of care
Attention to and involvement of providers in the system
Intersystem collaboration*
Workforce development
Cultural competence and cultural relevance
Data-driven planning, management and performance evaluation
Compliance with federal mandates in establishing service priorities*

* Required by Senate Bill 2077.

CHAPTER 2 | *Overview of the Strategic Plan*

The Division accepts the challenge to act boldly and decisively and in collaboration with its partners and stakeholders to develop and implement a three-year strategic plan. While it is expected that change will be ongoing as the system continues to evolve and adjust to circumstances, the strategic plan provides a clear direction of the future. The plan establishes a policy framework for action at all levels of the system and performance objectives and benchmarks for accountability. Partnership, collaboration, communication and meaningful dialogue are necessary among all levels of the system.

The strategic plan renews the promise that consumers will have an opportunity for growth, recovery and/or self-determination. Improving mental health, developmental disabilities and substance abuse services and meeting the complex needs of the state's residents is a long standing goal in North Carolina. A state strategic plan that is jointly developed by stakeholders and agency staff revisits the vision and the purpose of transformation.

As the necessary strategies are implemented over the next three years, it is the Division's desire that the system will evolve to become more responsive to feedback and accountability measures will be expanded and continually refined. This vision can only be realized through partnership with LMEs and other state agencies and the collaborative efforts of all stakeholders.

Purpose of the State Strategic Plan for 2007-2010

In 2006, the North Carolina General Assembly specified changes to the implementation of reform of the mental health, developmental disabilities and substance abuse services system in House Bill 2077, Session Law 2006-142. These changes include provision of a clear and concise plan for service provision and the prudent use of local and state resources. The Division has identified specific goals for the next three years, including benchmarks of progress toward the goals. This document presents North Carolina's strategic objectives for further transformation of the system.

The state strategic plan advances the planning blueprint for the transformed system and establishes measurable outcomes. The strategic plan outlines priorities and details strategies that will be accomplished over the next three years with the current staffing and funding levels. All levels of the system are addressed in the strategies through performance objectives and benchmarks.

This plan describes the achievable actions that support progress in the system's transformation and marks out

steps with timeframes to achieve the objectives in specific areas. The Division will monitor, evaluate and report progress on the strategic plan's objectives.

Process of Development

Immediately after the legislation was passed in July 2006, the Division prepared a request for proposals (RFP) to hire a consultant to assist the Division with the three-year strategic planning process. This process during the fall of 2006 resulted in a contract with Technical Assistance Collaborative, Inc. (TAC) to provide technical assistance beginning January 2007. The team of TAC consultants included a number of individuals with expertise in planning, research and evaluation of mental health, substance abuse and developmental disabilities services. Especially important is TAC's extensive prior consulting experience in North Carolina.

- Early in January 2007, the Division's Executive Leadership Team began the strategic planning process with an initial list of issues and goals for the upcoming three years. The Division made a conscious decision that the strategic plan would be measurable and would only include objectives that could be achieved with existing financial and staff resources. If additional funding is forthcoming, the Division will update the plan.

- The Division's Management Leadership Team, the State Consumer and Family Advisory Committee, directors of LMEs, and the External Advisory Team provided input to the Executive Leadership Team resulting in a revised list.

- During mid to late January, the consultants provided four events on strategic planning for the Executive Leadership Team; the Division planning, quality management and LME liaison staff; the Management Leadership Team; and LME directors and planning staff. As a result of this process, the Executive Leadership Team selected five objectives as the most essential for moving system transformation forward.

- Next, Division leadership and management, Division teams, the consultants and the External Advisory Team identified needed action steps for each objective. Selection criteria specified that action steps must:

  - *Be activities for which the Division can and will hold itself accountable.*
  - *Result in improved outcomes for consumers and families.*
  - *Be concrete critical actions that result in obvious successes for the overall system.*

- *Produce concrete progress by the end of three years.*
- *Create an agenda for the Division and its partners at the state and local levels.*
- *Address concerns raised in the Long-Range Plan and Funding Allocation Report.*

❖ The Executive Leadership Team finalized the objectives, action steps and milestones presented in Chapter 3. The timing and sequencing of milestones was based on current staff resources and the need for additional resources to accomplish these tasks. In addition, consideration has been given to the potential use of the Mental Health Trust Fund to support these efforts.

❖ The Division's planning team prepared the draft State Strategic Plan 2007-2010 for distribution for the 30-day public comment. During this 30-day period, the Division continued to examine the best measures for each objective of the potential effects on consumer outcomes and system performance.

❖ Following the receipt of comments from stakeholders, the Executive Leadership Team, the consultants and the planning team reviewed the public comments submitted. The final state strategic plan was prepared for publication on the web by June 30, 2007 and hard copies were printed for distribution to selected stakeholders.

CHAPTER 3 | *Strategic Objectives and Action Steps*

The strategic plan is organized into five objectives. The objectives define the work that the Division is committed to undertake between July 1, 2007 and June 30, 2010. The strategic objectives are:

- Establish and support a stable and high quality provider system with an appropriate number and choice of providers of desired services.
- Continue development of comprehensive crisis services.
- Achieve more integrated and standardized processes and procedures in the mental health/developmental disabilities/substance abuse services system.
- Improve consumer outcomes related to housing.
- Improve consumer outcomes related to education and employment.

The five objectives are equally important; they are not placed in a particular order. These five objectives and strategies for their accomplishment are described in this chapter. Two or more action steps are identified as important for accomplishing each objective. Two or more milestones are defined to clarify what activities and deliverables must be accomplished for each action step and by when. Therefore, the structure used in the following sections looks like:

The Five Objectives Work Together

Successful implementation of the crisis system is dependent on a highly qualified provider system. A highly qualified provider system is dependent on adequate training as well as standard protocols and expectations for utilization management and claims payment. Improved outcomes for consumers related to housing is dependent on consumers taking responsibility for participating in their own person-centered planning, as well as the design of high quality protocols to assure person centered planning and continuity of care.

Therefore, accomplishment of some of the action steps under one objective may be dependent on the completion of other action steps in the same objective or in another objective. The dates for milestones have been chosen to correspond to a necessary sequencing of related milestones, plus recognition of limited resources for implementation at any one time. In addition, time has been allowed for engaging partners at the state level, such as the Division of Medical Assistance and the Division of Vocational Rehabilitation, and at local levels with LMEs, local governments as well as providers of mental health/developmental disabilities/substance abuse services and other community agencies.

The Plan Requires Accountability

Progress will be measured in terms of the timely completion of the deliverables and activities as defined in the action steps and milestones. In addition, the overall effectiveness of these endeavors will be measured in terms of outcomes for consumers and changes in system performance over time. These are described in Chapter 4.

Each objective is described in the following sections of this chapter. Each section describes what the specific strategic objective means for consumers and the system. It identifies current issues and barriers, what problems must be overcome and what impedes progress. Such an environmental scan becomes the basis for the action steps.

It is important to recognize that a plan is a dynamic process and neither the Division nor any part of the mental health/developmental disabilities/substance abuse services system can control the many variables - including financial limitations – that affect the outcomes. What is written in statute and rule outlines the specific authority of the Division, Local Management Entities, local governments, consumer and family advisory committees and providers. Beyond that, it is the Division's responsibility to provide policy guidance and tools for managing the system through performance and process expectations at state and local levels.

Ultimately, successes and failures rest with all stakeholders. With everyone's participation and commitment, the definition and accomplishment of the objectives should produce concrete, visible progress and changes for consumers and families within three years.

OBJECTIVE Establish and support a stable and high quality provider system with adequate number and choice of providers of desired services

A system of providers of mental health, developmental disabilities and substance abuse services that is stable and high quality is absolutely necessary to meet the varying needs of consumers and also family members. Desired services are based on strengths and are either evidence-based or the best practices known at any given time. A stable and highly qualified provider system includes community services and best practices offered at state operated facilities. Such services are constantly evolving.

A stable provider system means providers that exercise efficient and effective business management practices. Stable may also mean consistency in staffing with low turnover rates. Such practices ensure the longevity of the provider and its staff. Consumers must be able to count on the provider agency and its staff to be reliable, compassionate and responsive. Additionally, consumers need access to assistance to obtain and coordinate services and promptly address issues encountered in community living.

High quality means each provider consistently meets and exceeds performance standards in the services offered to consumers. The standards are those required by service definition, by endorsement, by Medicaid enrollment, by professional organizations, by national accrediting bodies and by DHHS and LMEs. A qualified provider offers safe and effective services and employs trained staff that meets all requirements. The services offered are evidence-based or best practices. Furthermore, providers demonstrate the ability to effectively and efficiently provide services and supports consistent with each individual's person-centered plan. Significant changes in a person's needs or circumstances promptly trigger consideration of modifications in the person-centered plan. Overall, consumers can count on providers to offer their best in helping them toward self-determination and/or recovery.

Currently, providers have been conditionally endorsed by Local Management Entities to provide specific services. Before they achieve full endorsement, agency and individual providers must demonstrate that they possess the requisite skills, competencies and qualifications to serve and support consumers effectively. Provider audits reveal that appropriate staffing and training is needed; turnover rates among staff are high; and person-centered planning is not applied as intended. Some services are being provided in greater quantities than envisioned in lieu of referring consumers to other services that might be more appropriate to meet the person's needs.

Choice means that there are a sufficient number of quality providers offering a service or array of services in a given geographic area. Given that the system has moved away from a franchise system to a competitive market system, any provider organization has the opportunity to participate in the system as long as they follow endorsement and enrollment requirements and other standards. In many areas, this market system is still evolving. Choice also indicates that consumers and families are informed and have access to assistance in choosing, hiring and/or managing service providers.

Another issue is a clear definition of the fundamental menu of services that are ideally available to consumers for each age and disability group. Such benefit designs spell out what the state wants to purchase from a provider system. This array of services is about consumers' access to services and supports that are consistent with their person-centered plans. Even when funding is limited, there must at least be a minimum of basic types and amounts of services available for consumers. Benefit designs specify expectations for those essential services and recommendations for the order in which additional services are offered as funding becomes available.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns of establishing and supporting a stable and high quality provider system.

OBJECTIVE Stable and High Quality Provider System

Action Step 1 Develop and implement strategies to inform and empower consumers and families to fulfill their responsibility by actively participating in the person-centered planning process and by accessing services, exercising choice and rights, and expecting best practices and service quality.

MILESTONES

By June 30, 2008, analyze complaints and concerns filed with the Division to identify trends and issues regarding providers to inform Division policy guidance and a communication plan.

By June 30, 2008, develop a communication plan in conjunction with the state and local consumer and family advisory committees that includes strategies and materials to inform all stakeholders about how to access the system, participate in person-centered planning, exercise choice, exercise rights, and expect best practices and quality.

By June 30, 2009, work with LMEs' customer service and consumer affairs offices to publicize information about providers through a variety of media including the NC Care Link web site.

By June 30, 2009, provide technical assistance to LMEs' customer service and consumer affairs offices and to state and local consumer and family advisory committees in the implementation of strategies to inform and empower consumers including their active participation in the development of person-centered plans and assess strategies of the communication plan on an ongoing basis.

By June 30, 2010, assess the results and refine the strategies of the communication plan to make them more effective in empowering consumers and also families.

Action Step 2 Establish and communicate a benefit design and provider sufficiency standards that reflect best and preferred practices for each age/disability group.

MILESTONES

By June 30, 2008, identify variables that impact a benefit design.

By June 30, 2008, establish and communicate the fundamental benefit design and provider sufficiency standards for mental health, developmental disabilities and substance abuse target populations.

By June 30, 2009, implement the benefit designs and provider sufficiency standards statewide.

By June 30, 2010, develop procedures for reviewing the benefit designs on an ongoing basis and complete the first annual evaluation.

Action Step 3

Define statewide provider performance standards (including national accreditation, service definitions, federal and state requirements) and clarify LMEs' responsibility for holding providers accountable for those standards and reporting about performance to the public.

MILESTONES

By June 30, 2008, work with the Division of Medical Assistance (DMA) and other applicable entities at the state level to clarify and develop provider quality and performance expectations, measures and indicators of fidelity, quality and performance, and tracking processes.

By June 30, 2008, provide guidance to LMEs on their responsibility for holding providers accountable and reporting performance of all providers.

By June 30, 2009, train staff of LMEs in reporting and using data to monitor and improve quality of providers.

By June 30, 2010, review and refine provider quality and performance expectations, measures and indicators and the methods for analyzing consumer outcomes as needed.

Action Step 4

Establish strategies for providers to enhance quality and effectiveness (through training, technical assistance, workforce development, quality improvement, national accreditation and other activities).

MILESTONES

By December 31, 2007, assess the progress of providers in preparing for national accreditation.

By December 31, 2007, establish strategies for workforce development.

By June 30, 2008, provide technical assistance to LMEs as they assist providers with regard to enhancing quality and effectiveness and accreditation.

By June 30, 2009, implement a training process that allows providers to build internal training capacity to meet requirements of specific services and to adhere to best practice models.

By June 30, 2010, implement the short-term strategies of the Division's workforce development plan.

By June 30, 2010, examine financial incentives to move the system to best practices to support quality and effectiveness.

Action Step 5	Continue to implement best practices in state-operated facilities to complement community services.

MILESTONES	
	By December 30, 2007, define and implement standard protocols for admission, medical clearance, discharge and information sharing among the state hospitals and alcohol and drug abuse treatment centers (ADATCs) and the LMEs.
	By June 30, 2008, develop ICF-MR bed transfers as a vehicle for downsizing of developmental centers.
	By June 30, 2008, increase utilization of acute and sub-acute services in alcohol and drug abuse treatment centers (ADATCs).
	By June 30, 2008, establish three neuro-medical treatment centers in the state.
	By June 30, 2009, establish consistent policies and procedures for clinical practices and corporate business practices for all state-operated facilities as appropriate to the lines of business.
	By June 30, 2009, develop and implement policies and protocols that ensure continuity of care between community and state-operated facilities.
	By June 30, 2009, identify appropriate fidelity measures for evidence-based practices and administer these measures semi-annually for alcohol and drug abuse treatment centers (ADATCs).
	By June 30, 2009, complete planning and design for facilities to replace Cherry Hospital.
	By June 30, 2010, complete planning and design for facilities to replace Broughton Hospital.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning, access to services, promotion of best practices, quality management, system efficiency and effectiveness and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes
Increased percent of consumers receiving timely and adequate care.
Increased percent of consumers given a choice of providers.
Increased percent of consumers participating in the development of their person-centered plans.

System Performance
Increased public access to provider performance reports.
Increased proportion of public resources spent on evidence-based and best practices.
Increased percent of providers that are nationally accredited for each disability group.
Increased number of providers who meet statewide provider performance standards.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Request for proposals or applications that invite providers through LMEs to apply for funding to:
  - *Support the development of evidence-based practices.*
  - *Transitional support for providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based service providers.*
  - *Transitional support, such as start-up funding, technical assistance, etc., for developing providers as LMEs continue to divest direct service provision.*
  - *Transitional support for both the development of additional service providers and the enhancement of existing providers to increase service availability to facilitate the downsizing of state-operated facilities through reduced utilization.*

OBJECTIVE Continue development of comprehensive crisis services

A comprehensive crisis service system is critical to stabilize the system across all disabilities statewide. Such a comprehensive system must be prepared to meet the needs of any individual who experiences a crisis related to a mental health or substance abuse problem or a developmental disability. Such a comprehensive system must be prepared to provide appropriate services that are evidence-based or best practices. At the community level, a comprehensive crisis service system must be totally integrated with the existing community medical and public safety emergency response system.

While state facilities clearly have an important role in a comprehensive crisis service system, admission to a state psychiatric hospital should be the choice of last resort. All too often, individuals who experience such a crisis are quickly transported by police to hospital emergency rooms or to state-operated psychiatric hospitals. Improved access to commitment evaluations and community resources serving as alternatives to state hospital admission are important in providing a comprehensive crisis system and in decreasing inappropriate state hospital admissions. Use of the state psychiatric hospitals or the alcohol and drug abuse treatment centers is quite appropriate when community options are exhausted and a thorough crisis evaluation has ruled out all less restrictive community alternatives.

When existing consumers of the system have a fully developed person-centered plan, including a crisis prevention/intervention plan and an assessment of health risk and safety, the consumers, family members and first responders know what actions are needed to promote health, independence and safety; to prevent escalation of the crisis; and to intervene in a way that is appropriate for the person. Crisis prevention begins with a good risk assessment and a plan that anticipates the supports needed for the person in the eventuality that a crisis occurs. Often, the crisis can be resolved in a timely manner in the person's home community given a comprehensive array of crisis services. Training of first responders regarding crisis planning and management is also critical. Currently, individualized planning as person-centered plans, including crisis plans and transition plans, is not fully exercised statewide as intended.

Currently, each LME has submitted a plan for developing comprehensive crisis services in its geographic area. As mandated by the North Carolina General Assembly, each plan must provide community crisis services for any person experiencing crisis due to a mental health or substance abuse

problem or developmental disability. Further, the General Assembly appropriated funding for development of these services and for their ongoing operation. The Division contracted with consultants from Technical Assistance Collaborative, Inc., to assist with review of plans and provision of technical assistance to LMEs in their implementation through June 2008.

The Division is also aware of the possibility of wide-scale disasters (such as natural disasters and medical epidemics) and that communities and state-operated facilities must be prepared for such events. The Division, each state-operated facility and each LME has developed disaster plans for behavioral health response and recovery. Consumers must be cared for by responding to their individual needs, including health support, medications, and safety.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns for continuing the development of comprehensive crisis services.

OBJECTIVE **Comprehensive Crisis Services**

Action Step 1 Develop and implement strategies to ensure that consumers and also family members participate in crisis service planning at all levels (personal, local and state) so they understand how to access crisis services and their roles in advocacy for appropriate use of resources.

MILESTONES

By June 30, 2008, provide training for state and local consumer and family advisory committees in their roles as advisory bodies regarding crisis service access, planning and implementation.
By June 30, 2008, encourage consumers and family members to understand and participate in consumer-centered approaches to crisis intervention, such as Crisis Intervention Teams (CIT) a pre-booking jail diversion program that includes a specialized law enforcement response unit for people with mental illness.
By June 30, 2008, assist consumers and family members in understanding their participation in crisis planning at all levels, particularly development and implementation of individualized crisis plans.
By June 30, 2009, provide guidance for consumers and LME customer service offices in the development of crisis information materials.

MILESTONES

By June 30, 2009, work with LME customer service and consumer affairs offices to publicize crisis services providers through a variety of media including the NC Care Link web site, and to publicize how to report complaints about crisis services.

Action Step 2

Coordinate and implement comprehensive crisis services for each age/disability group that:

- Incorporates the functions and responsibilities of state-operated facilities, LMEs and community providers; and
- Ensures continuity of care and support across all components of the crisis system.

MILESTONES

By June 30, 2008, set expectations for multi-year development of comprehensive crisis system and designate functions, expertise and responsibility of state-operated facilities, LMEs and community providers.

By June 30, 2008, provide technical assistance to LMEs in implementing approved regional and LMEs crisis service plans.

By June 30, 2008, provide guidance on the standardized person-centered plan including a risk assessment, a crisis prevention/intervention plan, and transition plan for individuals at risk of or discharged from inpatient or out of home care.

By June 30, 2008, increase the capacity for acute treatment at all alcohol and drug abuse treatment centers (ADATCs).

By June 30, 2008, establish guidance that ensures continuity of care and supports for consumers among LMEs, local providers, and state-operated facilities to ensure transition from emergency/crisis services to an ongoing provider.

By June 30, 2009, ensure LMEs fully implement their approved crisis services plan in coordination with assigned crisis region.

By June 30, 2010, assess remaining gaps in the development of all crisis service system components and services, including appropriate behavior supports for services for individuals with developmental disabilities, and provide Mental Health Trust Funds to address gaps and needs.

Action Step 3

Design and implement comprehensive training on crisis intervention and stabilization techniques for LMEs and providers.

MILESTONES

By June 30, 2008, prepare a comprehensive training plan for crisis intervention and stabilization techniques that includes development, implementation and maintenance of ongoing training.

By June 30, 2008, secure contracts between the Division and education and training consultants to develop curricula and/or provide training as identified in the training plan, including first responder, person-centered planning, crisis planning, transition planning, crisis prevention/ intervention techniques, skills training and treatment.

By June 30, 2009, initiate all applicable recommendations of the training plan.

By June 30, 2010, evaluate and revise training plan as needed.

Action Step 4

Establish cooperative relationships and protocols for continuity of care at state and local levels including general hospitals, primary care physicians, clinics and networks and other community agencies essential to effective crisis response systems.

MILESTONES

By December 31, 2008, work with LMEs and provide guidance and examples of memoranda of agreement regarding the importance of developing local agreements about handling crisis situations with hospitals, local offices of Community Care of North Carolina (CCNC) and other representatives of the primary health care system.

By December 31, 2008, ensure collaboration with hospital emergency departments on crisis response and stabilization.

By December 31, 2008, work with LMEs to establish protocols for appropriate use of local law enforcement and courts in crisis situations.

By December 31, 2008, implement legislation passed pertaining to first level commitment evaluations.

Action Step 5

Develop and implement methods to assure LMEs' authority and accountability and to explore performance incentives regarding admissions to and utilization of state psychiatric hospitals, alcohol and drug abuse treatment centers and developmental centers.

MILESTONES

By February 28, 2008, analyze the statutory authority for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to define the roles and responsibility of LMEs with regard to admission to state-operated facilities.

By June 30, 2008, establish and communicate targets for each LME and for each facility by exploring performance incentives for both admissions and discharges.

By June 30, 2008, the Division will analyze and publish performance results for LMEs and facilities related to their admission and utilization targets.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and supports, access to services, promotion of best practices, quality management, system efficiency and effectiveness, early intervention and prevention, and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes
Increased percent of consumers with crisis prevention/intervention plans.
Reduced rate of re-hospitalization within 30 days of inpatient discharge.
Decreased rate of preventable deaths of consumers including suicide, homicide and other violence.

System Performance
Increased availability of local crisis services.
Reduced percent of hospital admissions for short-term stays.
Increased continuity of care for consumers between crisis services and appropriate ongoing services.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Request for proposals or applications that invite providers, through LMEs, to apply for funding as a supplement to other crisis service funding that may be available to:
  - *Support one-time start up costs for crisis services such as minor facility modifications and acquisition of equipment; or*
  - *Transitional support for crisis service providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based crisis service providers that link seamlessly to LMEs, state facilities and other community-based service providers; or*
  - *Short-term transitional support for crisis service operations until newly developed crisis services can become self-sufficient via Medicaid and state support fee-for-service billings.*

OBJECTIVE **Achieve more integrated and standardized processes and procedures in the MH/DD/SA services system**

The success of any system or business is directly related to its practices that integrate its parts and facilitate smooth operations, continuous quality improvement and constant communication and flow of information. Success does not mean rigidity and cookie cutter mandates, but encourages creativity, flexibility, evolution and growth. This objective is intended to promote three basic premises: (1) consumers must have consistent access to services across the state based on their level of need and with reasonable adjustment for urban and rural areas; (2) the public mental health/developmental disabilities/substance abuse service system will operate more effectively and efficiently if all LMEs and providers adopt standard processes and procedures, at a minimum, regarding particular areas of operation; and (3) there must be consequences for lack of accountability at every level.

The areas of operation that are of major concern are utilization management of state-funded services, provider management, clinical protocols, care coordination, information systems, and LME functions. Every level of the system (Division, state partners, LMEs, providers, local partners and consumers) is accountable for the success or failure of the system. Consumers must be accountable for their individual needs and standing up for their rights. Providers must be accountable to the people they serve and to LMEs. LMEs must be accountable to consumers in its geographic area, to county governments and to the Division for the expenditure of public funds, and to the state for oversight of the providers it has endorsed as well as compliance with laws, rules and established standards and policies. The Division must be accountable for the expenditure of public funds and for the overall operation and success of system performance and outcomes for consumers.

The importance of systematic quality management systems and consistent expectations across the system is also reinforced by the increased expectations expressed in the last few years by the Centers for Medicare and Medicaid Services regarding the administration of Home and Community Based Waivers. The federal Centers for Medicare and Medicaid (CMS) now requires states to describe their procedures for establishing provider capacity, monitoring individual plans of care, protecting individual health and safety and assuring that services outlined in plans of care are provided. The data generated from these discovery processes must in turn be shown to be used to remediate individual and provider related issues. Further the state must describe how findings from monitoring processes are used to support policy, practice, and other improvements in the service system.

Currently, with the provider system still under development, there is inconsistency in what services are available across the state as well as the quality of those services. There is inconsistency in accountability. There is inconsistency in processing of claims and payments to providers. There is inconsistency in the availability and flow of information for monitoring system operations to assure clinical, programmatic and technical quality and to measure and report outcomes for consumers. These problems limit how well we can manage funding and implement adequate care coordination for those consumers who are at highest risk and consequently are the highest cost to the system.

The Division must set expectations and measure the impact for the entire system. However, this objective confronts an inherent conflict within the North Carolina system as currently established. That is, the Division is given responsibility for designing, implementing and overseeing a system over which it has limited authority. Consequently, in addition to proposing rules based on statutory language, the Division can at best provide policy guidance based on its best clinical and professional judgment of what is best for the people the system serves. To be most successful that guidance must be based on conversations with all stakeholders of the system. Considerable time is needed to research the issues, hold the conversations, gain consensus, and formally communicate the guidance. However, if the policy guidance is not in rule, the Division cannot enforce its implementation. Unfortunately, some stakeholders do not comply and yet expect funding to continue.

The Department of Health and Human Services will enter a new three-year contract with each LME for 2007-2010. In addition, each LME has prepared a three-year local business plan that outlines how it will carry out the functions that the state is contracting with it to provide for its geographic area. The Division will use a model for equitable allocation of funding to LMEs to support the functions. As mandated by the General Assembly, the Division must monitor how well each LME carries out the functions and in the event that an LME does not successfully carry out a function, the Division must provide technical assistance to improve the situation or remove the function from an LME's responsibility and contract with another entity to fulfill that function. This is the most practical way for the Division to encourage a LME to utilize the Division's policy guidance.

It is important to note that the Division has contracted with consultants from Technical Assistance Collaborative, Inc. (TAC) to assist with the development and implementation of standard practices for utilization management of state funded services, provider management, and measurement and reporting of system performance and consumer outcome data through June 2008.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

OBJECTIVE **Integrated and Standardized Processes and Procedures**

Action Step 1 Develop strategies and materials to inform consumers and also family members of statewide standard processes and procedures, to support their legal rights and to support them in processing their complaints and concerns.

MILESTONES

By June 30, 2008, provide training to LME's customer service and consumer affairs offices regarding client rights protection and other functions of those offices.

By June 30, 2008, provide guidance to LME's customer service and consumer affairs offices on the development of consumer-friendly materials in a variety of formats regarding rights, filing complaints, and utilization of standard system processes such as appeal processes (Medicaid and non-Medicaid), availability and quality of providers, and other standard processes that impact consumers.

By June 30, 2009, assist state and local consumer and family advisory committees and client rights committees to review quarterly customer services data reports and data and to recommend appropriate responses to these reports.

Action Step 2 Develop and implement uniform practices, clinical protocols and performance expectations for utilization review and utilization management for state funded services.

MILESTONES

By December 30, 2007, complete information collection and analysis of current LMEs' utilization management and utilization review practices, clinical criteria and protocols for state funded services, and compare to the practices of the Division of Medical Assistance and ValueOptions as well as the criteria for Medicaid services for each service and target population.

MILESTONES

By June 30, 2008 develop utilization management/utilization review system design, standards, performance indicators and quality assurance processes for utilization management/utilization review functions for state funded services within the standard benefit designs for each age/disability group.

By June 30, 2009 complete LME training and implementation of standard utilization management/utilization review functions and practices for state- funded services.

Action Step 3

Work with LMEs and other stakeholders to develop and implement uniform practices and performance expectations for provider management, including provider endorsement, provider monitoring and claims payment.

MILESTONES

By December 31, 2007, develop and implement standard processes and procedures for provider endorsement including conditional and full endorsement, and withdrawal of endorsement.

By December 31, 2007, develop standardized provider monitoring tools and manual.

By June 30, 2008, develop and implement standard procedures for service authorizations and processing claims related to state funded services.

By June 30, 2008, develop and implement standard processes for provider monitoring.

By June 30, 2009, integrate provider level consumer outcomes and performance measures into the provider quality and performance monitoring system.

Action Step 4

Work with LMEs, providers and other stakeholders to design and implement uniform high quality clinical systems and protocols to assure care coordination and protocols for monitoring and continuity of care for consumers.

MILESTONES

By June 30, 2008, develop and implement processes and procedures for referral and continuity of care of MH/DD/SAS consumers across a variety of service types and providers.

By June 30, 2008, develop and implement processes and procedures for care coordination between state-operated facilities and LMEs community services.

MILESTONES

By June 30, 2008 work with DMA to develop continuity of care standards for Medicaid providers and protocols for consumers receiving care from Medicaid providers.

By June 30, 2008, share with DMA and ValueOptions protocols for evidence-based practices and audit reviews.

By June 30, 2009, develop standardized quality management tools for monitoring individual care.

Action Step 5

Work with LMEs and the Division of Medical Assistance to develop a consistent framework based on person-centered planning and best practice for care coordination of high risk and/or high cost consumers.

MILESTONES

By June 30, 2008, submit a draft rule to the Mental Health Commission that defines criteria for identifying high risk and high cost consumers.

By June 30, 2009, develop and implement standard procedures for planning and implementing services for high cost and/or high risk MH/DD/SAS consumers.

By June 30, 2009, collaborate with DMA and ORDHRD to develop processes and procedures for participation in Community Care of North Carolina (CCNC) and coordination of generic health issues, hospital utilization, etc. for MH/DD/SAS consumers.

Action Step 6

Implement systemwide outcome and performance measures, and conduct quarterly and annual analyses of outcome and performance data for use by managers and staff at all levels of the system to assure the quality, effectiveness and accountability of the mental health/developmental disabilities/substance abuse services system.

MILESTONES

By December 31, 2007, refine current measures and reporting mechanisms.

By June 30, 2008, define how systemwide outcome and performance measures will be used at the state level for planning and system improvement.

Action Step 7

Replace or upgrade existing information systems to respond to a changing business environment and federal reporting requirements.

MILESTONES

By December 31, 2007, clarify the procedures and legalities for sharing data on mental health, developmental disabilities and substance abuse consumers between the Division of Medical Assistance (DMA), ValueOptions, DMH/DD/SAS, LMEs and providers to facilitate responsibilities and accountability at every level of the system.

By December 31, 2007, implement a statewide notice of privacy and consent form to cover sharing of all consumer information for the Division's client data warehouse (CDW), consumer outcomes, claims data, incident data, and system performance measures.

By June 30, 2010, implement an electronic health record and standardized clinical information system for all consumers in the Central Regional Hospital with long-range plans for implementation at all state psychiatric hospitals.

By June 30, 2010, explore a long-term plan to provide incentives for LMEs and providers to utilize a standardized electronic health record capable of sharing and transmitting consumer information and treatment data in real time.

By June 30, 2010, explore an effective interface of consumer information between state facilities and LMEs within the constraints of federal and state regulations.

Action Step 8	Develop standardized processes and procedures for monitoring Local Management Entity (LME) functions.

MILESTONES	
	By June 30, 2008, develop and provide guidance and implement strategies to streamline and standardize LME managerial and administrative processes and procedures.
	B7 June 30, 2008, specify the elements of a public report on LME management, budget and administration that LME boards must review on a monthly basis.
	By June 30, 2008 develop for state and local levels standard quality management expectations to employ outcome and performance data to assure continuous improvement of best practices and to encourage clinical excellence and protection of consumer rights and dignity.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and support, access to services, promotion of best practices, quality management, system efficiency and effectiveness and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes
Increased rate of care coordination for high cost/high risk consumers.

System Performance
Increased percent of consumer data received by LMEs and the Division according to established time frames.
Increased timeliness of claims processing for non-Medicaid funded services.
Increased percent of annual non-Medicaid and federal service funds spent proportionately throughout the year by age/disability group and overall.
Reduced rates of over-utilization and under-utilization of state funded services.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Provision of financial assistance to LMEs and providers to implement electronic clinical/ health record systems capable of sharing and transmitting data about all persons served in real time.

OBJECTIVE Improve consumer outcomes related to housing

Housing is a basic need and every individual that the system serves needs the opportunity for increased accessible, safe, decent, affordable housing with the supports and services based on individual needs and choices. Every provider must realize the importance of housing for the people they serve, including keeping children in their home communities. Therefore, housing must be addressed in every consumer's person-centered plan.

For many who experience mental health or substance abuse problems or developmental disabilities, housing can be difficult to obtain or maintain. The difficulties may be associated with costs, need for services or supervision, licensing, and just the difficulty of navigating the complex and complicated housing system. Individuals who are discharged from state-operated facilities may end up homeless due to these difficulties.

Permanent supportive housing integrates permanent, affordable housing with the supportive services needed to help people with disabilities access and maintain stable housing in the community. Permanent supportive housing is a nationally recognized model being replicated throughout the country as a proven, cost-effective solution to preventing and ending homelessness among low-income people with disabilities. Permanent supportive housing is typically targeted to people with serious and long-term disabilities including mental illnesses, developmental disabilities, substance use disorders, physical disabilities and chronic health conditions such as HIV/AIDS. In addition to challenges in accessing housing, these populations often have co-occurring disabilities, resulting in complex service needs that require flexible services and supports to establish and maintain long-term housing stability. Key components of permanent supportive housing that facilitate successful housing tenure include:

- Individually tailored and flexible supportive services that are voluntary, can be accessed 24-hours-a-day/7-days-a-week, and are not a condition of ongoing tenancy;
- Leases that are held by the tenants without limits on length of stay; and
- Ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Studies on the housing preferences of people with disabilities have consistently shown a desire to live in independent housing that is integrated in the community, and greater satisfaction and perceived choice with the permanent supportive housing model.

Creating integrated housing options in the community for people with disabilities is also aligned with the U.S. Supreme Court's Olmstead decision that requires a choice of housing options for people in institutions who would prefer to live in integrated housing in the community. In addition to promoting greater choice, self-sufficiency and community integration, research has demonstrated positive impacts in terms of cost-effectiveness and improved quality of life, housing stability and health and behavioral outcomes for those it serves.

The Division recognizes housing as a significant issue for the people we serve and currently has one staff person that oversees and supports a housing specialist in each of about 20 LMEs. In addition, the Division participates in the Governor's task force on housing and in the Department of Health and Human Services' housing effort.

While the housing specialists in LMEs are currently devoted to housing programs for consumers of the system, broad housing competence is needed at the state and local level. Housing competence means having the knowledge about state laws pertaining to housing, the federal fair housing law and programs, having the skills of how to get and keep housing, how to get access to subsidies and lease accommodations, how to utilize various payment methods, how to negotiate with landlords, and how to resolve housing problems. Given that housing is a highly complicated and evolving area of programs and funding for which the system does not have major responsibility, providers responsible for person-centered planning need to be able to recognize when a consumer needs assistance with getting or maintain housing, what housing programs are available and who to contact to access the programs. The LME housing specialist could provide ongoing training and information to providers.

The Division is participating in a three-year pilot project to develop housing assistance teams that will teach ACT Teams how to access housing for their consumers.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

OBJECTIVE Housing

Action Step 1

Involve consumers in promoting the aspects of the communication plan (developed in the objective on the provider system) that emphasizes the role that stable housing plays in treatment, recovery, self-determination and/or full inclusion in the community.

MILESTONES

By June 30, 2008, analyze complaints and concerns filed with the Division to identify trends and issues regarding housing to inform Division policy guidance.

By June 30, 2008, ensure that Division staff providing customer service is aware of appropriate contacts and resources regarding housing.

By June 30, 2008, provide guidance and materials for LME customer service staff to communicate housing options available for consumers.

By June 30, 2010, convene training, presentations or workshops for consumers as well as family members to increase awareness about housing options.

Action Step 2

Develop strategies for implementing the Division's long-term integrated housing plan and build upon the MH/DD/SAS Commission's housing recommendations with revisions as needed.

MILESTONES

By June 30, 2008, identify unmet housing needs for specialized population groups (such as consumers who are homeless or at high risk of loss of housing, living in supported care facilities, people with physical disabilities, discharged from jail, and children moving back into home communities).

By June 30, 2008, work with consumers to identify the range of safe, affordable housing options by age/disability groups that meet the needs of consumers.

By June 30, 2008, update the Division's housing plan to incorporate the Housing 400 Initiative and other initiatives supported by DHHS.

By June 30, 2008, examine housing options and develop strategies for ensuring accessible housing alternatives for specialized populations (such as safe, stable housing for the homeless; housing that promotes independence for those in supported care facilities).

By June 30, 2008, define the Division's role in working with DHHS, the North Carolina Housing Financing Agency and others in the state-level housing community.

MILESTONES

By June 30, 2008, develop and provide guidance for LMEs about the full continuum of housing options, how to conduct an environmental scan and how to develop a local housing plan.

By June 30, 2008, publish the Division's revised long-term integrated housing plan.

By June 30, 2009, publish the first annual update of the Division's long-term housing plan.

By June 30, 2010, examine the results and make recommendations for the feasibility of expansion of the pilot Homeless Mental Health Housing Initiative use of housing support teams and include this in the annual updated housing plan if appropriate.

Action Step 3

Develop guidance and provide additional training and support to LMEs' housing specialists to increase knowledge and skills in all options regarding housing for consumers of mental health/developmental disabilities/ substance abuse services.

MILESTONES

By June 30, 2008, increase the knowledge and skills of housing specialists including fair housing practices, the requirements and procedures for accessing tax credit units for people with disabilities and the importance of linkages between housing and supportive services.

By June 30, 2009, provide support for housing specialists in training Local Management Entities' (LMEs') staff, providers responsible for person-centered planning as well as advocacy groups regarding housing issues.

By June 30, 2010, develop and implement technical assistance, training and workforce development activities for LMEs and providers to improve capacity and effectiveness in assisting consumers to attain and sustain permanent housing.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and supports, access to services, promotion of best practices and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes
Increased percent of consumers by disability that report having accessible, safe, stable housing in the community.
Increased percent of person-centered plans that have goals addressing consumers' housing preference.
Increased numbers of formerly homeless individuals with disabilities that are placed in housing.

System Performance
Increased number of affordable and accessible housing units available.
Increased number of collaborative relationships at the state level that inform and support housing specialists at the local level.
Increased outreach to homeless individuals.

Use of Mental Health Trust Funds

- Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:
  - Pilot Homeless Mental Health Housing Initiative to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with ACTT and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the county.
  - Continue housing initiative through a joint effort with DHHS, LMEs and the North Carolina Housing Finance Agency (NCHFA) to leverage funds and increase the availability of housing

resources and options for individuals with mental illness, developmental disabilities and substance abuse problems.

- Provision of MH/DD/SAS on a transitional basis, i.e., until sufficient ongoing revenues are available, to support individually tailored and flexible support services that will enhance successful housing opportunities for individuals with disabilities.
- Support for non-recurring cost necessary to support successful housing utilization such as rental deposits, utility deposits, and furnishings.

OBJECTIVE Improve consumer outcomes related to education and employment

Developing and using one's talents and skills are essential to experiencing a rich and fulfilling life. Regardless of the personal limitations or challenges that any individual experiences, each has gifts to be shared within a community. This is equally true for those who experience challenges related to mental health, substance abuse or developmental disabilities. Every individual served in the public system deserves the opportunity for education, employment and other meaningful daily life activities based on individual needs and choices. Every provider must discover the importance of education or employment for each person they serve. Therefore, every consumer's person-centered plan must include specified activities that relate to the development and use of individual skills in daily life, whether through education, employment and/or other meaningful daily activities.

Part of the challenge of developing a community-based services system is transforming the community itself to be inclusive and accept diversity. The vision calls for communities to work together to enable consumers to live successfully in their communities. This includes opportunities for education, employment and asset development. This is a long-term endeavor, but we must begin.

Best practices for children and adults with developmental disabilities increasingly revolve around the use of individualized educational and employment supports to maximize a successful job placement. "Without employment, or a means of generating income, individuals with intellectual disabilities have limited freedom."[5] In the past, people were relegated to segregated vocational settings that offered few opportunities for individual choice or career paths. As the system has evolved, efforts are directed at ensuring that adolescents receive job counseling and skills preparation before they graduate so that there is a more seamless transition into employment. For adults seeking jobs, there are a range of creative solutions including the use of job coaches and the identification of natural supports within the workplace.

"The great majority of people with severe mental illness desire competitive employment, and evidence-based supported employment is currently the most effective way to help them achieve their goal. Evidence-based supported employment emphasizes the following: competitive jobs that are based on a person's preferences for type and amount of work, integrated work settings, job-seeking when the unemployed person expresses interest, minimal pre-vocational preparation and

[5] The President's Committee for People with Intellectual Disabilities, *A Charge We Have To Keep: A Road Map to Personal and Economic Freedom for Persons with Intellectual Disabilities in the 21st Century*, 2004.

assessment, and follow-along supports from mental health and vocational specialists to maintain the job or transition to another one. Supported employment has been endorsed by the President's New Freedom Commission on Mental Health (2003), the Surgeon General (1999), the National Alliance for the Mentally Ill (2001), the National Institute of Mental Health (1999), the Substance Abuse and Mental Health Services Association (www.mentalhealthservices.com), and many other federal organizations, state agencies, advocacy groups, and private foundations."[6]

The challenges are primarily two-fold. First, this requires effective linkages and collaboration partnering with and supporting the initiatives of agencies and organizations that provide education and employment expertise and services. At the state level, the Division's primary partners are the Department of Public Instruction, the University of North Carolina and the N.C. Community College System, and the Division of Vocational Rehabilitation. Local partnerships to develop and support consumer's access to educational programs and jobs include the local school systems, community colleges and offices of vocational rehabilitation. Secondly, staff at LMEs and among providers who are responsible for person-centered planning must know about available employment services and programs and have the skills to assist the people they serve to find appropriate activities that reflect each individual's choice.

Action Steps and Milestones

The following action steps and milestones address these issues and concerns.

[6] Deborah R. Becker, M.Ed. and Robert E. Drake, M.D., Ph.D. *Supported Employment for People with Severe Mental Illness :A guideline developed for the Behavioral Health Recovery Management Project*; New Hampshire-Dartmouth Psychiatric Research

OBJECTIVE Education and Employment

Action Step 1

Involve consumers and also family members in promoting the aspects of the communication plan (developed in the objective on the provider system) that emphasizes the role that education and employment play in self-determination and/or recovery.

MILESTONES

- *By June 30, 2008, analyze complaints and concerns filed with the Division to identify trends and issues regarding education and employment.*
- *By June 30, 2008, involve consumers and family members in developing strategies for emphasizing education and employment across age/disability groups.*
- *By June 30, 2008, provide guidance to LME customer service offices in the development of materials regarding the role education and employment play in self determination and recovery in a variety of media and languages.*
- *By June 30, 2010, provide training workshops and/or presentations for consumers and also family members to increase awareness of education and employment.*

Action Step 2

Develop and communicate guidance for LME staff and providers about the importance of addressing education and employment in all person-centered plans.

MILESTONES

- *By June 30, 2008, research supported education programs and models (see models in Kansas and other states) and potential funding for these programs.*
- *By June 30, 2008, provide training to LMEs about education and employment programs and importance of addressing education and employment in all person-centered plans.*
- *By June 30, 2009, revise service definitions regarding supported employment for transition age youth and adults.*
- *By June 30, 2009, work with consumers to define and strengthen peer directed and delivered services that can be included in person-centered plans.*
- *By June 30, 2009, provide training and technical assistance to LMEs and providers on best practice supported employment approaches tailored to age/disability populations.*

Action Step 3

Expand and enhance joint efforts with the Division of Vocational Rehabilitation to provide training for state and local staff and to provide employment opportunities for consumers of mental health, developmental disabilities and/or substance abuse services.

MILESTONES

By June 30, 2008, conduct initial cross training for state and local staff as indicated in the memorandum of agreement with the Division of Vocational Rehabilitation and plan for this on an annual basis.

By June 30, 2008, exchange policy and programmatic information on an ongoing basis with the Division of Vocational Rehabilitation regarding supported employment and related services to better meet the needs of eligible individuals.

Action Step 4

Work at the state level to develop strategies and disseminate information for consumers related to maintenance of benefits (e.g., Medicaid, Supplemental Security Income, Social Security Disability Income) while engaging in employment.

MILESTONES

By June 30, 2009, disseminate information through LMEs' customer service offices and advocacy groups to families and individuals regarding the benefits of employment and the ways in which benefits can be protected.

By June 30, 2010, develop guidance, training, TA and other resources to improve the competence of LME staff regarding federal requirements and employment opportunities.

Action Step 5

Develop a plan and communicate guidance to LMEs for youth (up to age 21) consumers to move into jobs or vocational development or post secondary education.

MILESTONES

By June 30, 2009, work with Division of Vocational Rehabilitation and the Department of Public Instruction to develop transitional work plans for youth.

By June 30, 2009, identify resources available for working with youth who dropout of school to support their obtaining their high school diploma or GED.

By June 30, 2009, provide guidance for community support workers and targeted case managers in schools to provide skill building to keep youth in school.

Action Step 6	Expand the availability of supported employment and job placement services and supports.

MILESTONES	
	By June 30, 2009, assess costs to expand supported employment and job placement services.
	By June 30, 2009, work with LMEs to identify and assist individuals who desire and could benefit from supported employment.
	By June 30, 2009, monitor data regarding the numbers of people receiving supported employment to determine current availability.
	By June 30, 2010, review best and evidence-based practices in supported employment and available tool kits, literature, and publications and disseminate information to LMEs, providers, consumers, and also families.

Measures of Success

Progress will be measured in terms of the timely completion of the action steps and milestones shown above. In addition, the overall effectiveness of these endeavors to accomplish the objective will be measured in terms of outcomes for consumers and changes in system performance over time. The performance domains that are related to this objective include individualized planning and support, access to services, promotion of best practices and consumer focused outcomes.

Measures of this objective include:

Consumer Outcomes
Increased percent of consumers participating in supported employment.
Increased percent of consumers with developmental disabilities that like the jobs and/or other daily activities that they have.
Reduced rates of dropout, suspension and expulsion from school among youth consumers (up to age 21).
Increased percent of educational or job placements for youth consumers (up to age 21).

System Performance
Increased percent of LMEs providing public information to consumers and families about education and employment opportunities and maintenance of entitlements and other public benefit options while employed.
LME staff and case managers are knowledgeable about employment and the maintenance of entitlements.
Increased number of employment opportunities for consumers.

Use of Mental Health Trust Funds

Mental Health Trust Funds could effectively be used to support achievement of this objective in the following ways:

- Transitional funding of proposals/applications from providers, in conjunctions with LMEs, that demonstrate effective and promising approaches to support positive consumer outcomes related to education and employment.

Relationship of the Strategic Objectives to Long-Range Plan

This strategic plan addresses many of the conclusions and recommendations of the Long-Range Plan prepared by Heart of the Matter, Inc. and Pareto Solutions, LLC, in December 2006. Table 2 provides a crosswalk of the major recommendations from that report to the strategic objectives by identifying relevant action steps as described above. To facilitate this process, Table 2 shows the categories of Chapter VI of the Long-Range Plan report for this table rather than the detailed discussion in each category.

2

	Response of State Strategic Plan to Recommendations of Long-Range Plan				
Categories of Recommendations from the Long-Range Plan	**Objective:** High Quality Provider System	**Objective:** Comprehen-sive Crisis System	**Objective:** Standardized Processes & Procedures	**Objective:** Consumer Outcomes related to Housing	**Objective:** Consumer Outcomes related to Education & Employment
Foundations	Action step 1			Action step 1	Action step 1
Rules[7]	As needed	As needed	As needed	As needed	As needed
Information Systems		Action Step 4	Action Steps 4, 6, 7 & 8		
Service Inadequacy	Action Steps 2, 3 & 4	Action Step 2	Action Steps 3, 4 & 6	Action Step 2	Action Step 5
Population, Prevalence & Treated Prevalence			Action Steps 6 & 8	Action Step 2	
Per Capita Spending		Action Steps 2 & 4	Action Step 4		
Service Utilization	Action Steps 3 & 4	Action Steps 3 & 5	Action Steps 2, 3, 4 & 8	Action Step 2	Action Step 2 & 4
Projected Start-up & Total Funding Needed	Action Steps 4 & 5	Action Steps 2 & 5			
Monitoring & Oversight	Action Step 1	Action Step 5	Action Step 6		

[7] Note that the drafting of appropriate rules is a detailed task that will be included in the achievement of a milestone and action step as appropriate. The Division drafts and proposes rules for consideration by the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, which then provides them for public consideration and final disposition. The length of time required for enacting a rule depends on comments received.

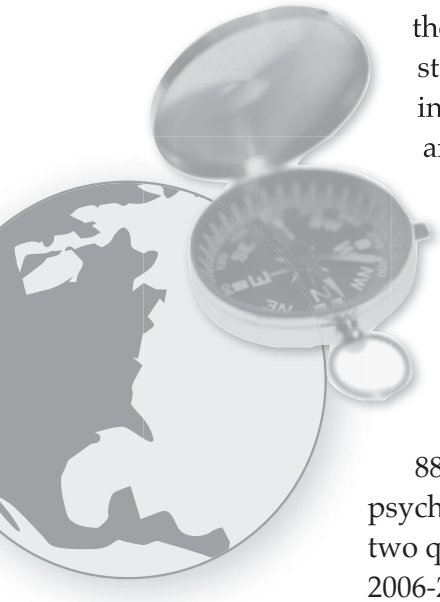
CHAPTER 4 | *Measures of Results*

As defined in the previous chapter and sections related to each objective, there are two ways in which the success of this strategic plan will be measured.

First, the Division will measure progress of implementation by monitoring the action steps taken to accomplish each objective. In other words,

- Was each milestone accomplished in a timely manner?
- Was each action step accomplished as intended?
- Were challenges or barriers successfully addressed?

Secondly, and more importantly, the Division anticipates changes for consumers and other stakeholders as a result of this strategic plan. Therefore, the overall effectiveness of the five strategic objectives will be measured in terms of outcomes for consumers and in changes in system performance over time.



Data collected during 2006 and 2007 will be used as baseline data against which the Division will measure overall progress and effectiveness. For example, 88 percent of discharges from state psychiatric hospitals during the first two quarters of state fiscal year 2006-2007 were for consumers with lengths of stay for 30 days or less.[8] Over half of these were for consumers who were discharged within seven days of admission. When crisis services are fully implemented in communities, the Division expects both of these percentages to drop. Where prior year data are not immediately available, the Division will develop baselines during the first year of data collection against which progress can be measured.

The successful effects of some of the objectives may be more readily apparent than others. For example, considerable effort and time beyond the three years of this plan may be necessary to fully develop employment opportunities in communities for consumers who desire to and can work. The three years will be used to lay the groundwork. Considerable visible change should be apparent throughout the state with regard to local crisis services within the three years.

In House Bill 2077, the General Assembly requires that the Division track and report performance in the following domains or areas:

- Individualized planning and supports.
- Access to services.
- Consumer focused outcomes.
- Promotion of best practices.
- Quality management system.
- System efficiency and effectiveness.

[8] See *Semi-Annual Report to the Joint Oversight Committee on MH/DD/SAS, Statewide System Performance Report, SFY 2006-07, Spring Report.*

[9] See www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm for copies of these semi-annual reports.

- Early intervention and prevention.

These domains are used in the previous chapter to guide the Division's selection or creation of measures of effectiveness. These domains were first reported in the Division's semi-annual report to the Legislative Oversight Committee.[9] The Division has contracted with consultants from Technical Assistance Collaborative, Inc. and Human Services Research Institute to assist in the refinement of measures.

The Division will use measures from the semi-annual report on statewide performance to the Legislative Oversight Committee to track success as a result of the state strategic plan objectives. In addition, the Division will use measures from a number of reports on consumer outcomes, annual statistics, consumer adverse events and LME performance. The sharing of information among providers, LMEs and the Division is critical to having adequate data to measure the effects of the objectives and the success of this endeavor for the entire system.

Table 3 summarizes the consumer outcomes and system performance measures of the five objectives selected by the Division.

3 Measures of Objectives

Objective	Consumer Outcomes	System Performance
Provider System	Increased percent of consumers receiving timely and adequate care. Increased percent of consumers making a choice of providers. Increased percent of consumers participating in the development of their person-centered plans.	Increased public access to provider performance reports. Increased proportion of public resources spent on evidence-based and best practices. Increased percent of providers that are nationally accredited for each disability group. Increased number of providers who meet statewide provider performance standards.

[9] See www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm for copies of these semi-annual reports.

3	Measures of Objectives	
Crisis Services	Increased percent of consumers with crisis prevention/intervention plans. Reduced rate of re-hospitalizations within 30 days of inpatient discharge. Decreased rate of preventable deaths among consumers including suicides, homicides and other violence.	Increased availability of local crisis services. Reduced percent of hospital admissions for short-term stays. Increased continuity of care for consumers between crisis services and appropriate ongoing services.
Integrated and Standardized Processes	Increased rate of care coordination for high cost/high risk consumers.	Increased percent of consumer data received by LMEs and the Division according to established time frames. Increased timeliness of claims processing for non-Medicaid funded services. Increased percent of annual non-Medicaid and federal service funds spent proportionately throughout the year by age/disability group and overall. Reduced rates of over-utilization and under-utilization of state funded services.
Housing	Increased percent of consumers by disability that report having safe, stable housing. Increased percent of person-centered plans that have goals to address consumers' housing preference. Increased numbers of homeless individuals with disabilities placed in housing.	Increased number of affordable and accessible housing units available. Increased number of collaborative relationships at the state level that inform and support housing specialists at the local level. Increased outreach to homeless individuals.

3	Measures of Objectives	
Education/ Employment	Increased percent of consumers with stable employment. Increased percent of consumers participating in supported employment. Increased percent of consumers with developmental disabilities that like the jobs and/or other daily activities that they have. Reduced rates of dropout, suspension and expulsion from school among youth consumers (up to age 21). Increased percent of educational or job placements for youth consumers (up to age 21).	Increased percent of LMEs providing public information to consumers and families about education and employment opportunities and maintenance of entitlements and other benefits while employed. LME staff and case managers are knowledgeable about employment and the maintenance of entitlements. Increased number of employment opportunities for consumers.

In addition to the strategic objectives and related measures set forth in this document, the Division will also focus business planning efforts to help ensure efficient and effective resource management with the public mental health, developmental disabilities and substance abuse system and increased accountability for Medicaid and non-Medicaid services. This shall be addressed through, but not limited to the following:

- Review of quarterly fiscal monitoring reports submitted by LMEs. Such reports encompass funding which flows through the LMEs and reflects quarterly updates on overall expenditures and revenues and the balance between the two, accounts payable and accounts receivable.
- Review of monthly LME Systems Management expenditure reports which reflect actual expenditures associated with LME management activities.
- In conjunction with the DHHS Office of the Controller, review and resolution of any audit findings contained in local LME annual audit reports and Management Letters.
- Periodic review of service payments processed for payment to the LMEs for state funded services through the Integrated Payment and Reporting System (IPRS) to ensure that funds are being earned on a timely basis.
- Increase the ability of the Division, through improved reporting, to track the provision of all services, whether

provided and billed through IPRS and the Medicaid Management Information System (MMIS) on a fee-for-service basis, or provided through the use of county funds or state allocated resources which are outside of the IPRS billing and payment system, i.e., non-Unit Cost Reimbursement.

- Ongoing review of data related to (a) number of persons served, i.e., increases or decreases in penetration rates, (b) number and mix of service units provided – both Medicaid and state-only, (c) rate at which Division allocated resources are being utilized, and (d) average per person and per event cost.
- Ongoing coordination, assessment and review of all LME requests to move funding from Unit Cost Reimbursement (UCR) to non-UCR categories.
- Ongoing and targeted monitoring of providers of services to ensure that service delivery is documented and performed in the manner envisioned for each service.
- In conjunction with the Division of Medical Assistance and the LMEs, oversight of the provider endorsement process to help ensure that only qualified providers participate in the public mental health, developmental disabilities and substance abuse system.
- Provision of guidance to LMEs regarding the authorization of state-only services and, in conjunction with the Division of Medical Assistance (DMA), to the DMA contractor engaged for authorization of Medicaid funded mental health and substance abuse services.

CHAPTER 5 | *Implementation Structure and Process*

Conceptual Framework

Based on research, a persistent problem encountered throughout reviews of transforming systems is the lack of a common language and the lack of a common framework for thinking about implementation. This strategic plan intends to commit to setting priorities in these areas by defining objectives, action steps and milestones. Based on the review of continuous learning over the last several years, the Division has arrived at a conceptual framework for implementation of well defined practices and programs. This plan demonstrates the five essential components that are necessary to ensure implementation of the designated activities are accounted for within this plan.

The five essential components that support implementation are:

1. **Source** - This component validates that learning has occurred within the system and that learning has been taken into account by developing specific milestones and actions to support additional system development.
2. **Destination** – The Division will consider adopting, supporting and funding the installation and ongoing use of innovations (such as evidence-based practices and benefit designs).
3. **Communication Link** – This plan understands and assumes responsibility for communication in all relevant areas/topics.
4. **Feedback** – Mechanisms are outlined to provide a regular flow of reliable data/information about the performance of the Division and other organizations.
5. **Influence** – The plan recognizes the framework in which social, economic, political and historical factors impinge directly or indirectly on people, organizations or the system.

What is Implementation?

For the purposes of this plan, implementation is a specified set of activities designed to put into practice communication, policy or program(s) of known or intended positive outcomes for consumers and families. According to this definition, implementation processes are purposefully defined by the objectives, action steps and milestones within the state strategic plan. In addition, the activities or policies being implemented are described in sufficient detail so that the system and all members can detect its presence and strength. The state strategic plan incorporates two sets of activities 1) intervention-level activity and 2) implementation-level activity. These two activities provide

accountability of outcomes to consumers, families and the system.

It is important to have an "implementation headset" while reading this plan. This type of perspective suggests that strategies of leadership, organizational frameworks and consumer input are valued as non-negotiable.

Degrees of Implementation

During the three years of this state strategic plan, various purposes and outcomes of implementation have been planned in different ways. The strategic plan categorizes implementation in three ways.

- Paper implementation will be acknowledged by implementing new policies and procedures promising incorporation of stakeholder feedback across all settings. Within this process is a sincere commitment to evaluate any and all redundancy of paper work and other meaningless activities the systems currently has in place. The system will continue to use communications bulletins, implementation updates and other various communications to provide leadership and direction as outlined in Chapter 6.

- Process implementation is noted throughout the plan by creating and designing new ways to participate with different stakeholder groups, by providing leadership forums, by organizing trainings and by standardizing processes across systems, while developing strategies to create positive and effective work environments to ensure benefits to consumers and families.

- Performance implementation is reflected by means of putting procedures and processes in place in such a way that the identified functional components of change are used with good effect for consumers. The plan is written in such a way that it structures implementation to be accountable for actual benefits to consumers, organizations and systems. It requires more careful and thoughtful efforts as described by the actions in creating methods to acquire data concerning consumer and provider outcomes and to monitor system performance to ensure higher quality of services.

Next Steps

Once the state strategic plan is finalized and published July 1, 2007, the Division will develop an internal detailed implementation plan using technical monitoring tools to identify specific tasks for each milestone and accountability for each. Implementation may involve existing teams and newly created and time-limited work groups. Implementation will also involve current contracts with consultants from Technical Assistance Collaborative, Inc.,

HSRI, and/or various grants including the North Carolina Adolescent Substance Abuse Treatment Project and the Strategic Prevention Framework State Incentive Grant from the federal Substance Abuse and Mental Health Services Administration. The Executive Leadership Team will monitor progress on an ongoing basis.

The involvement of representatives of consumers, family members, providers, LMEs, advocacy groups, other state agencies and other stakeholders is essential to implementation of this large endeavor. Coordination with the Medicaid State Plan and North Carolina Health Choice is essential as the Division develops standardized processes and procedures to make the system more effective and efficient.

The extensiveness to which implementation of this strategic plan is achieved and timeliness are dependent on funding. With existing funds, Division staffing resources are limited and therefore, progress is slower as some tasks will have greater priority than others. With additional funds and staff resources, progress can be achieved more quickly.

In state fiscal years 2006 and 2007, the Division, through contracts with independent consultants, continued the ongoing process of (1) identifying gaps in services at the local level – including transition to best and promising service practices as well as improving penetration rates and continuity in service provision; (2) quantifying the level of all resources (Medicaid, state funds, etc.) needed and available to close such service gaps; and (3) establishing an allocation system that would help ensure funding equity, i.e., equal access to services throughout the state, among LMEs.

During the next three years, state fiscal years 2008, 2009 and 2010, the Department and Division will continue to work with the General Assembly, and all related committees, consumers, LMEs, providers and other stakeholders, to operationalize the appropriate findings and recommendations contained in the reports from the above-referenced independent consultants. The continuing challenges will be: (a) prioritization of service initiatives within available resources, (b) identification of resources, and (c) ability to allocate funding in a manner that moves the overall system towards equity in service access throughout the state.

A key aspect in moving the overall system towards equity in access to services throughout the state will be to determine the most feasible method of allocating public resources to accomplish equity in service access. Such a process will involve several variables, including: (a) identification of services currently available; (b) quantifying the levels of service which are needed within, or to be available to, each LME; (c) determining the cost of funding the gap between existing and needed services; (d) identification of resources from Medicaid, state appropriation and local funds, including

county funds, insurance and first party payments; and (e) adoption of a methodology that moves the public system towards this equity in a measured and incremental manner. Continuing this effort in state fiscal year 2008 will remain a high priority within DHHS and the Division in order to lay the foundation for a reasonable level of implementation in state fiscal years 2009 and 2010.

Inherent in each of the objectives and action steps, set forth herein, is the need for resources to meet the objectives. During state fiscal year 2008, the Division will develop strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of state resources in order to move the system towards equity in service access throughout the state.

Strategic Plan for Use of Mental Health Trust Funds

The availability of the Mental Health Trust Fund (MHTF) is key to the implementation of several of the strategic objectives of this plan. The MHTF will be used in accordance with the requirements of the General Assembly. How the Division proposes to use new funds is outlined under each objective and summarized in Table 4 below. In terms of strategic planning, the potential uses of the Mental Health Trust Fund set forth within this document represent the major initiatives but not necessarily every potential use of Mental Health Trust Fund resources.

Other than utilizing the resources as obligated within the state fiscal year 2007 Mental Health Trust Fund Plan and expended in a subsequent fiscal year, MHTF resources shall, in accordance with G.S. 143C-9-2, be allocated to LMEs and only utilized to:

- Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in the state's mental health, developmental disabilities and substance abuse services facilities.
- Facilitate reform of the mental health, developmental disabilities and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate services to clients.
- Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings, including departmental restructuring of services.

Priorities for the utilization of Mental Health Trust Fund resources shall include: (a) continued development of local and regional crisis systems and capacity; (b) development of additional community-based service capacity for all age/disability groups to enhance the continuity of service, reduce waiting lists and facilitate the transition of

individuals from state facilities to community-based services; (c) within the scope of the plan developed by the Division to phase-in a more equitable distribution of resources MHTF will be utilized to assist with start-up and transitional costs as new services are developed and existing services expanded; and (d) support for improved housing, consumer education and employment.

4	Summary of recommended use of Mental Health Trust Funds
Objective: Stable & High Quality Provider System	Request for proposals or applications that invite providers through LMEs to apply for funding to: Support the development of evidence-based practices; Transitional support for providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based service providers; Transitional support, such as start-up funding, technical assistance, etc., for developing providers as LMEs continue to divest direct service provision. Transitional support for both the development of additional service providers and the enhancement of existing providers to increase service availability to facilitate the downsizing of state-operated facilities through reduced utilization.
Objective: Comprehensive Crisis Services	Request for proposals / applications that invite providers, through LMEs to apply for funding as a supplement to other crisis service funding that may be available to: Support one-time start up costs for crisis services such as minor facility modifications and acquisition of equipment; or Transitional support for crisis service providers to enhance their business and information technology functions to help ensure an array of stable and viable community-based crisis service providers that link seamlessly to LMEs, state facilities and other community-based service providers; or Short-term transitional support for crisis service operations until newly developed crisis services can become self-sufficient via Medicaid and state support fee-for-service billings.
Objective: Integrated and Standardized Processes & Procedures	Provision of financial assistance to LMEs and providers to implement electronic clinical / health record systems capable of sharing and transmitting data about all persons served in real time.

4	Summary of recommended use of Mental Health Trust Funds
Objective: Improved Housing Consumer Outcomes	Pilot Homeless Mental Health Housing Initiative to address homelessness for people with disabilities by partnering staff devoted to the development of housing options with ACTT and Community Support Teams. The combination of housing emphasis with treatment has been proven to be effective in other areas of the county. Continue housing initiative through a joint effort with DHHS, LMEs and the North Carolina Housing Finance Agency (NCHFA) to leverage funds and increase the availability of housing resources and options for individuals with mental illness, developmental disabilities and substance abuse problems. Provision of mental health, developmental disabilities and substance abuse services on a transitional basis, i.e., until sufficient ongoing revenues are available, to support individually tailored and flexible support services that will enhance successful housing opportunities for individuals with disabilities. Support for non-recurring cost necessary to support successful housing utilization such as rental deposits, utility deposits, and furnishings.
Objective: Improved Education/ Employment Consumer Outcomes	Transitional funding of proposals / applications from providers, in conjunctions with LMEs, that demonstrate effective and promising approaches to support positive consumer outcomes related to education and employment.

CHAPTER 6 | *Communications Plan*

The Division recognizes the significance in communicating progress made as this strategic plan is implemented. The Division will report progress on applicable measures, to include action steps delivered with timelines in addition to reporting on changes in outcomes for consumers and system performance. In addition, the Division will establish a customer-friendly means to respond to questions about the implementation of the strategic plan from all stakeholders.

Strong emphasis on collaborative efforts with other agencies, stakeholders, community members, consumers, and advocacy groups will be highlighted on the Division's website, as collaboration is vital to the success of the reform process. The Division plans to regularly update the public on progress with the Division's transformation efforts on a quarterly basis. In addition, annual progress reports about the strategic plan will be generated and distributed to the General Assembly's Legislative Oversight Committee and to all other stakeholders.

In addition, the Division will continue its existing communications regarding rules, policy changes, plans, strategies related to reform, pertinent information to consumers, family members, service providers, advocacy groups, government entities, and stakeholders through email broadcasts, web postings and regular mail.

- Communication Bulletins - Various communications regarding policy changes and updates are distributed to stakeholders as a portable document format (.PDF) file letter and are housed on the Division's website. Communication Bulletins are numbered and labeled to assist the reader in locating the document with ease.
- Implementation Updates – The purpose of implementation updates is to communicate important joint policy decisions of the Division with the Division of Medical Assistance regarding transformation. These are similarly sent via "DMH Broadcast" to a list of applicable stakeholders, providers, departments, divisions, and advocacy groups within the state of North Carolina.
- Announcements and other publications - Other information is posted on the Division's website to include the current budget, the Division's annual report, quick facts on quality management, statistical data, Town Hall Meeting notices, reports, and archived reports. The list of groups in receipt of current communications includes, but is not limited to:
  - *Legislative Oversight Committee*

- *State Consumer and Family Advisory Committee*
- *Local Consumer and Family Advisory Committees*
- *N.C. Commission for Mental Health, Developmental Disabilities, Substance Abuse Services*
- *Advocacy organizations and groups*
- *North Carolina Association of County Commissioners*
- *County Managers*
- *County Board Chairs*
- *North Carolina Council of Community Programs*
- *North Carolina Association of Directors of Departments of Social Services*
- *State Facility Directors*
- *LME Directors*
- *LME Board Chairs*
- *Department of Health and Human Services Division Directors*
- *Provider organizations*
- *Mental Health, Developmental Disabilities and Substance Abuse Services Professional Organizations and Groups*
- *Mental Health, Developmental Disabilities and Substance Abuse Services Stakeholder Organizations and Groups*
- *Other Mental Health, Developmental Disabilities and Substance Abuse Services Stakeholders*

Clinical and administrative trainings for providers across disabilities are posted on the website and emailed using "web trees" to providers of mental health, developmental disability, or substance abuse services in the state of North Carolina. This assists with ongoing professional development and skill-building among practitioners in the field.

Please visit the Division web site, www.ncdhhs.gov/mhddsas, for additional information, including

- Communication Bulletins.
- Implementation Updates.
- Target population descriptions.
- The Cultural and Linguistic Competency Plan.
- Service Definitions.

nc department
of health and
human services

State of North Carolina • Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
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